internists and family/general practitioners) group, 13% in the C group, and 25% in other specialties.

Results: Not surprisingly, the C (vs. G) group had higher mean expenditures ($7,658 vs. $6,407) and were more likely to have acute myocardial infarction or unstable angina than less severe IHD (27% vs. 22%). The mean expenditure excess for the C over the G group, however, was substantially greater for the acute IHD syndromes ($3,114) than for the less severe chronic IHD conditions ($107).

Conclusion: The higher expenditures of patients who chose cardiologists as their principal providers were predominantly in IHD patients with acute myocardial infarction and unstable angina, two groups most likely to have better health outcomes from specialty care.

8:45

879-2 Do Specialists Make a Difference in the Management of Unexplained Syncope?

M.E. Vloka, A. Sharma, D.D. Narula, F.A. Ehlert, J.S. Steinberg. *St. Luke's-Roosevelt Hospital Center and Columbia University College of Physicians and Surgeons, New York, NY, USA*

Syncope is a common cause of emergency room visits and hospitalizations. The causes of syncope are varied, sometimes serious, and often require extensive or provocative work-up prior to treatment. Given current trends in managed care, we evaluated the effect of specialist input on the diagnosis and treatment of syncope. We conducted a chart review of 76 consecutive pts (71 ± 18 yrs, 27 males) admitted over a 6 mo. period with syncope. 41 pts (Gp1), managed only by a primary physician, were compared to 35 pts (Gp2) who had ≥1 specialist (cardiology, electrophysiology, neurology) involved.

Results: Gp1 and Gp2 were similar in age (74 ± 16 vs 69 ± 9 yrs), history of heart disease (66% vs 63%), prior syncope (24% vs 14%, p = 0.09), and baseline sinus rhythm (80% vs 74%). There was no difference in the number of non-invasive tests (echocardiography, Holter, carotid Doppler, brain imaging, EEG, signal averaged ECG, cardiac stress test) performed (2.3 ± 1.6 vs 2.4 ± 1.5). However, Gp2 pts were more likely to have specialized tests (electrophysiology study, cardiac catheterization, tilt table) (0 ± 0 vs 0.7 ± 0.8). Importantly, Gp2 pts were twice as likely to have a diagnosis of the cause of syncope made (22% vs 49%, p = 0.026) and tailored therapy initiated (15% vs 37%, p = 0.03). Despite more specialized tests in Gp2, the length of stay did not differ (7 ± 8 vs 7 ± 5 days).

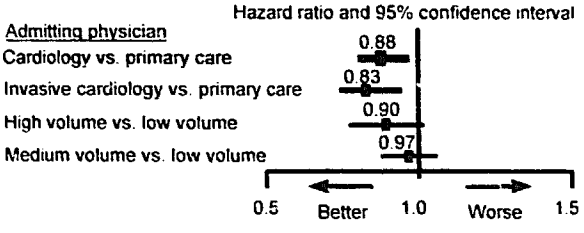
Conclusion: Cases of syncope in which a specialist was involved were more likely to have an etiologic diagnosis made and appropriate therapy initiated.

9:00

879-3 Mortality Following Acute Myocardial Infarction According to Physician Experience, Technical Training, and Specialty

J.G. Jollis, K.J. Anstrom, J.A. Stafford, D.B. Mark. *Duke Clinical Research Institute, Durham, NC, USA*

We previously demonstrated a relationship between admission by a cardiologist and lower mortality for 8,241 acute myocardial infarction patients over age 65. To understand the aspects of specialty care associated with better outcomes, we examined 1 year mortality according to experience (annual number of acute myocardial infarction admissions per physician) and technical training (invasive cardiologist). After adjusting for patient and hospital characteristics, there was a trend toward lower mortality for more experienced physicians regardless of specialty, and substantially lower mortality for physicians trained in cardiac catheterization.



While it is possible that unmeasured patient and hospital factors led to the better outcomes, this study suggests that physician factors involving both technical training and experience are associated with improved acute myocardial infarction survival.

9:15

879-4 Impact of Physician Type on Hospital Charges for DRG 127 (Heart Failure and Shock); Heart Failure Specialists Provide More Cost-effective Care

D. Chomsky, J. Butler, S. Davis, K. Dahle, J.R. Wilson. *Vanderbilt University Nashville, TN, USA*

Most patients with heart failure are currently managed by physicians with little specific expertise in heart failure. Transferring the care of such patients to heart failure specialists might improve outcomes and decrease costs. To test this hypothesis, we examined the influence of physician type on hospital charges for DRG 127 (heart failure and shock). From 4/95 to 3/97, 764 patients were admitted to Vanderbilt Medical Center for heart failure, of whom 211 were managed by 3 heart failure specialists (HFS), 159 by cardiologists (C), and 394 by internists and primary care physicians (PCP). Patients managed by HFS had a higher acuity, as evidenced by a higher mortality rate (HFS: 6%, C: 4%, PCP: 3%) and higher charges for outliers (>$15,000 total charges) (HFS: $29,183, C: $27,643, PCP: $23,767). The percentage of outliers was similar in all groups (HFS: 8%, C: 11%, PCP: 9%). When outliers were excluded, to partially correct for acuity differences, both length of stay (LOS) and total hospital charges were significantly lower in patients managed by heart failure specialists (* p < 0.01, ** p < 0.001 vs HFS):

	N	LOS	Charges/Patient
HFS	194	3.2 ± 1.8	$4899 ± 2779
PCP	359	3.8 ± 2.1**	$5848 ± 2810**
Cardiologists	142	3.7 ± 2.0*	$6474 ± 3007**

These findings suggest that heart failure specialists treat inpatients with heart failure more cost-effectively than other physician groups.

9:30

879-5 Impact of Focal Heart Attack Disclosure Document at the Time of Discharge on the Appropriate Management of Patients With Acute Myocardial Infarction

R.H. Mehta, E. Nolan, S. Das, G. Kearly, D. Karavite, P. Russman, K. Saran, K.A. Eagle, J. Nicklas. *Division of Cardiology; University of Michigan, Ann Arbor, MI, USA*

We developed a Heart Attack Discharge Summary (HADS) as a document to empower patients (PTS) to query physicians (MD) about key elements of acute myocardial infarction (AMI) care. The PTS and MD reviewed and cosigned the HADS at the time of discharge, documenting quality of AMI care indicators including use of discharge aspirin (ASA), ACE inhibitors (ACE), beta-blockers (BB), lipid lowering agents (LPA), avoidance of calcium-blockers (CB), copy of ECG (ECG) to the PTS, smoking cessation (SC), diet counseling (DC) and out-patient rehabilitation (OR). HADS use was variable among MD throughout the study. This analysis examines the relationship of using HADS and adherence to key discharge goals.

Methods: We studied 611 consecutive AMI PTS between 3/95 and 2/97. HADS was completed in 275 PTS. PTS who died (n = 76) and with missing follow-up (n = 4) were excluded. The mean age was 62 years (357 males and 178 females).

Results: The table lists % of PTS where quality indicators were met.

	N	ASA	BB	ACE	LPA
No HADS	256	96	90.8	86	56
HADS	275	99	97.6	95	72
p value	-	0.022	0.002	0.01	0.001
	CB	ECG	OR	SC	DC
No HADS	92	28	63	87	96
HADS	90	70	82	98	96
p value	0.47	<0.001	<0.001	0.001	0.83

Conclusions: 1. HADS use correlated with higher adherence to quality of care indicators for AMI. 2. PTS empowerment and MD reminders improve adherence to quality of care indicators for AMI.

9:45

879-6 The Importance of Physician Procedural Skills in Management Decisions for Acute Myocardial Infarction

J.G. Jollis, K.J. Anstrom, J.A. Stafford, D.B. Mark. *Duke Clinical Research Institute, Durham, NC, USA*

Previous work demonstrated that acute myocardial infarction (AMI) patients